South Carolina Department of Health and Human Services
Medicaid Quality Assurance Review Checklist

To: _____ **Date:** _____

BG#: _____ **Payment Category:** _____

You must cooperate with the federal review of Medicaid eligibility for the people listed below:

Medicaid Beneficiary Names

_____ _____

_____ _____

_____ _____

_____ _____

You must take the following action(s):

☐ Contact the Medicaid Office

☐ Complete the enclosed Medicaid Review form

☐ Provide _____

☐ Provide _____

☐ Provide _____

Please contact the Medicaid Office and/or provide the requested information by _____. Failure to respond to this request may result in the termination of Medicaid coverage for some or all of the beneficiaries listed above.

Eligibility Worker: _____

Address: _____

_____

Phone: _____ **Fax:** _____

You should also contact the Medicaid Office if you have questions or need assistance.